IN THE HIGH COURT OF JUDICATURE AT BOMBAY

CRIMINAL APPELLATE JURISDICTION

Criminal Appeal No.584 of 2002

1. Vaneeta Yeshwant Jadhav
aged about 47 years, permanently
residing at Central Railway Quarters,
Building No.3, Room No.11,
Dadasaheb Phalke Marg, Dadar,
Mumbai.

2. Buddeshwar Maruti Shirke,
Aged about 35 years, permanently
residing at Central Railway Quarters,
Building No.3, Room No.11,
Dadasaheb Phalke Marg, Dadar,
Mumbai.

(Both are presently undergoing
sentences imposed upon them at
Yerwada Central Prison,
Yerwada, Pune. ... ... Appellants
(Orig.Accused Nos.1 & 2)

Versus

The State of Maharashtra,
(At the instance of Sr. Inspector of
Police, Bhoiwada Police Station,
vide F.I.R. No.84 of 2000. ... Respondent

Mr.Nitin Sejpal with Ms.Pooja Bhojane for Appellants.

Mr.A.R. Patil, Additional Public Prosecutor for Respondent-State.

CORAM : DR.S. RADHAKRISHNAN &
SMT.ROSHAN DALVI, JJ.

Date of reserving the judgment : 18st October 2007

Date of pronouncing the judgment : 23rd November 2007

JUDGMENT : (Per Smt.Roshan Dalvi, J.)

1. The Appellants have challenged the judgment dated 2nd May 2002, under which they have been convicted for offences under Section 302 read with Section 34 of the Indian Penal Code and sentenced to suffer rigorous imprisonment for life and to pay a fine of Rs.500/- and in default, to suffer further rigorous imprisonment of one month.

2. The Appellants are the wife and the son-in-law of the deceased. The deceased and the children of Appellant No.2 lived together in the servants' quarters of Central Railway Officers' flat at Dadar, Mumbai. It is the case of the prosecution that the deceased-Yeshwant Ganpat Jadhav, husband of Appellant No.1, was unemployed for several years. He had suffered a paralytic stroke 8 years before the incident. He was bed-ridden. He was being looked after by Appellant No.1, his wife and their daughter one Sunita. The deceased had no home of his own. He was, therefore, living in the house of his daughter and the son-in-law along with his wife. The wife of the deceased had an illicit relationship with her son-in-law. It is the case of the prosecution that the wife of the deceased and his son-in-law committed the

murder of the deceased by the wife throwing two bottles of kerosene on the person of the deceased and the son-in-law throwing a lighted matchstick over him. The extent of burns suffered by the deceased were 70 to 75%, upon the general observation in the inquest panchanama. The postmortem report has shown 55% burns suffered by him.

3. It is the further case of the prosecution that the incident took place on 1.5.2000 at 9 a.m. when the daughter of the deceased Sunita had gone out of the servants' quarters in the officers' flat where she did domestic work. She came back upon hearing the shouts of the deceased and abuses of his wife cursing the deceased. She saw that the deceased, her father, was set a blaze. She removed him to the hospital. She gave the history of homicidal burns suffered by the injured to the doctor upon admission. An EPR entry was made. Police Officer was informed and called. The Police officer recorded the statement of the injured, which was treated as an FIR and a criminal case under the provisions of Section 307 of the Indian Penal Code came to be registered on 1.5.2000. The statement of the injured annexed to the FIR, running in 4 pages, shows the entire life-sketch of the injured after his marriage with Appellant No.1 since 1964. The statement shows how the incident took place.

4. Upon the injured having suffered severe burns, the Police Officer summoned the SEM and got a dying

declaration recorded. The dying declaration was a questionaire in a prescribed printed form, the particulars of which were got filled in by the SEM upon the say of the injured. The statement of the deceased as well as the dying declaration, recorded one after another, have been signed by the injured.

5. It is the prosecution case that the statement as well as the dying declarations were got recorded by the Police Officer and the SEM, respectively, after making inquiries with the doctor about the state of mind of the injured. After recording the statement of the injured, the Police officer gave it to the Constable with a direction to obtain the endorsement of the Medical Officer as per the earlier opinion of the Medical officer relating to the mental condition of the injured at the relevant time. Two of the four pages of the statement of the injured have been endorsed vertically in the margin by the relevant doctor, who had examined the injured.

6. The injured expired on 2.5.2000. Hence, the charge against the Appellants came to be altered to the charge under Section 302 of the IPC.

7. The prosecution has examined 8 witnesses. P.W.1 is the officer, who recorded the statement of the deceased and registered the FIR. He has deposed about how he was summoned, what was the state of the deceased when he arrived at the hospital, his talk with the doctor who was

attending to the deceased, the recording of the statement of the deceased and how he carried on investigation after the crime came to be registered. He has deposed about the relevant time of various steps taken by him from the time he was summoned until the investigation came to be completed. He has treated the statement of the deceased as his first dying declaration. Having known about the physical condition of the deceased, he having suffered homicidal burns, he has taken care to obtain another dying declaration through the SEM.

8. The SEM has been examined as P.W.3. He has deposed about how the dying declaration was recorded.

9. P.W.Nos.2 and 4 are the doctors who treated the deceased at KEM hospital. P.W.2 has deposed about the history of the patient given by his daughter and the condition of the patient upon admission as mentioned in the case papers of the deceased. P.W.4 has deposed about the examination of the patient and the endorsement made by him on the statement of the deceased, which came to be annexed to the FIR.

10. Upon the death of the deceased, P.W.5 made the postmortem of his dead body and had given the postmortem report showing the extent of the injuries on various parts of the body approximately totalling to 55% burns. He has given the cause of the death of the deceased as showing resultant

from about 55% epidermal to deep thermal burns, allegedly homicidal.

11. The prosecution has examined two witnesses with regard to what transpired at the time of the incident. These are the neighbour who is also a servant residing in the same servants' quarters as P.W.6 and the daughter of the deceased as P.W.7. Both of them have turned hostile. P.W.8 is the Police Inspector. He investigated the case and filed the chargesheet. The EPR entry relating to this case has been got produced by the accused / Appellants as Exhibit D-1 in the cross-examination of P.W.1.

12. The case of both the Appellants has been of denials simplictor.

13. It will be essential to set out the chronology of time of the date of the incident at the outset. The incident took place at 9 a.m. The deceased was admitted to the hospital at 10.20 a.m. The EPR entry has been made at 10.35 a.m. P.W.1, the Police Officer, received a message about the incident from KEM hospital at about 10.35 a.m. He reached the hospital within 15 minutes. The deceased was admitted as an indoor patient at 11 a.m. The deceased was initially examined 11.10/11.15 a.m. The history of the patient was recorded at that time. The doctor examined the patient and treated him from 11.15 a.m. onwards. Soon thereafter (upon the doctor certifying that the patient is capable of giving his

statement) his statement came to be recorded. The statement, as aforesaid, runs into 4 pages. Soon thereafter the SEM recorded the patient's dying declaration. This continued until 12.30 p.m. The endorsement of the doctors were obtain at 2.50 p.m. The spot panchanama was made at 3.30 p.m.

14. The contents of the two dying declarations of the deceased which form the back-bone of the prosecution case must be examined and considered alongside the medical evidence of the deceased.

15. P.W.1 has deposed that he was informed about this incident at 10.35 a.m. and reached the hospital within 15 minutes. He noticed that the deceased was in ward No.5 and was being treated by the doctor. He made inquiries with the doctor whether the injured was in a fit condition to make a statement. The doctor replied in the affirmative and thereafter he recorded the statement of the injured in the ward. It was faithfully and correctly recorded. It was read and explained to the injured. It was found to be correctly recorded. Thereafter the signature of the injured was obtained thereon. He also put the endorsement on it. Subsequently he obtained the endorsement of the doctor.

16. He has orally deposed about the dying declaration made by the deceased, who was then an injured in the hospital. His deposition shows that the deceased informed him that at

9 a.m. on that day while he was in his house, his wife poured kerosene on him and his son-in-law set him on fire. The witness identified the two accused. He further deposed that the deceased further told him that on hearing his shouts his daughter Sunita and neighbour Mohite came to his house and extinguished fire by pouring water over him. He identified the signatures of the deceased at two places on his statement as well as his own signatures at two places. The FIR was thus, marked as Exhibit-10 in evidence, having been proved by direct evidence. He identified the endorsement of the doctor obtained at 2.50 p.m. at two places on his statement.

17. He deposed that the injured was alone with him when he was recording the statement. After recording the statement, he went to the place of the offence and drew the spot panchanama. He identified the spot panchanama, which was marked as Exhibit-11. At the scene of the offence, he found, inter alia, two plastic bottles, one empty plastic kerosene can, one mattress,one match stick and one bidi bundle containing 3 bidies. He took charge of the articles. The articles were produced and marked by Article Nos.1 to 5 in Court.

18. He produced the station diary entry at Sr.No.13 at page No.330 of book No.8 when he left for KEM hospital which has been marked as Exhibit-12 in evidence. The next entry

was produced when he returned to the Police Station after the investigation on that day which has been marked as Exhibit-13. Similarly further entries of leaving and coming back to the Police station during investigation have been marked as Exhibits 14 to 17.

19. His cross-examination has been with regard to the recording of the deceased. It shows that he left the Police Station at about 10.25 a.m. and reached the hospital at 10.30 a.m. Upon receiving the first message from the hospital he has been shown the EPR entries in the EPR register at KEM hospital. He has identified the relevant entry which has been marked as Exhibit D-1. He has deposed that the daughter of the deceased Sunita was present in the hospital at the time of the recording of the EPR entires. He informed that the injured person was brought to the hospital by the daughter of the injured person and his neighbour one Mohite. His cross-examination shows that recording of the statement was completed by 12 Noon. He had inquired with the injured for about 30 minutes. He had sent the message to summon the SEM before he commenced recording the statement of the injured. The SEM had reached the hospital before he completed recording the statement.

20. His cross-examination shows reiteration of the fact that

he had made inquires with the doctor about the condition of the patient. He had refuted the suggestion that the doctor had stated that the patient's condition was serious. The patient was in the ward. His condition was not serious. His face and neck were burnt. The right hand palm of the injured was intact but the hands were burned. The front portion of the injured was totally burned. The cross-examination shows a further reiteration that he had obtained the permission of the doctor before recording the statement. In his presence, the doctor did not examine the patient or check the pulse and blood pressure. He had clarified that no written endorsement was given by the doctor before he commenced recording the statement. He has thereafter stated that he had asked a written permission from the doctor, though.

21. He has deposed that the SEM took 30 minutes to record the statement and had completed recording it by12.15 or by 12.30 p.m. The statement was handed over by the SEM to him. In his presence the SEM had not obtained the permission of the doctor before recording the statement. He did not make station diary entry about recording of the statement of the SEM in the hospital.

22. He waited in the hospital till 2.15 p.m. He asked the Constable to obtain endorsement of the doctor, which came to be obtained at 2.50 p.m. as reflected in the endorsements

themselves.

23. He has clarified in the cross-examination that he had obtained signature of the injured person on the statement made by him without taking help from any one and that he had not kept any witness to the recording of the statement of the injured. His cross-examination shows that the injured was not on saline when his statement was being recorded. The doctor visited the injured only once during that time. At that time he examined the patient. There were number of patients in the ward along with their respective relatives, nurses and doctors. The patient was talking incoherently. He did not find any difficulty in the talk. He registered the offence at about 4.25 p.m. after visiting the spot of the offence. He refuted the suggestion that the dying declaration was fabricated by him and the Police Inspector Kurne.

24. It will be interesting to note the contents of the statement of the deceased, which is a part of Exhibit-10 in evidence. The statement is the first dying declaration of the deceased. Upon the case of the accused that the dying declaration was fabricated and got-up and that the deceased could not have made such a dying declaration after having suffered 70 to 75% burns (as shown in the indoor case papers), it has been brought to our notice by the learned APP that the statement itself betrays the case of the accused that it is a fabricated document or could not have been so made. The statement

shows the life-sketch of the deceased from 1964 onwards. It gives detailed as well as intimate details about his life which none other could have provided. The fabricated statement would have contained only the particulars of the incident mentioned cryptically and not the details of how the deceased spent several decades of his life at his work place or at the residences of others where he lived.

25. The statement shows native place of the deceased at Mahad, Raigad and that he was educated till 4th standard. He obtained his first employment in 1964 in Premier Rubber Company. In 1976 the Company closed down. He lived in Dr.Ambedkar Zopadpatti with his wife Vanita (Appellant No.1). He had four children. The particulars of the name, age and their present position are mentioned. His daughter Sunita had two children, one Pradip, 8 years and Abhishek, 5 years old. One of his daughters passed away at the age of 18 years in about 1997. After his company closed down in 1976, he worked in a bidi shop. He performed the marriage of one of his daughters in 1995. He had a paralytic attack in which his left leg and left hand were affected. His mouth lost its shape. He came to live in the house of his brother and sister-in-law. He stayed there upto 1998. His wife resided with him. His brother and sister-in-law got fed up of him after sometime and he started residing with his daughter and his son-in-law (Appellant No.2). He started suspecting

that his wife had an affair with his son-in-law. Therefore, there had been many disputes. The disputes started since October 1999. He came to be bed-ridden about 2 months. Before the incident he saw his wife and his son-in-law sleeping together. He had abused her. Therefore, there were daily quarrels. His wife neglected him. She never gave him food regularly. She stopped giving him food for the last 7 days.

26. Thereafter he has stated about the incident of 1.5.2000. At 8.45 p.m. his daughter went for domestic work in the officers' quarters. His wife threw kerosene on his body and cursed him to die. Then she poured second bottle of kerosene on him. His son-in-law was standing there and seeing it. He threw a matchstick on his person and ran away. He shouted and his daughter came in. She started screaming to save him. His neighbour Mohite came in. His daughter and the neighbour extinguished the fire by pouring water on his person. His entire body was totally burnt. He was immediately shifted to the hospital. The doctor stated that on admission he had 70 to 75% burns. Thereafter he has given a summary of the incident. He stated that on 1.5.2000 at 9 a.m. his wife and son-in-law conspired to kill him by his wife pouring kerosene on him and his son-in-law Buddeshwar throwing the matchstick on his person and they be dealt with as per law. He had accordingly, assigned two

specific roles to the two Appellants.

27. It is argued that since he was utmost entirely burnt and was incoherent, he could not have given such a dying declaration and that the entire dying declaration must be disbelieved in view of his mental condition. Mr. Sejpal, the learned Advocate on behalf of the Accused entreated the Court to consider his statement / dying declaration along with indoor case papers, Exhibit-19 (collectively), showing his mental condition.

28. The indoor case papers show his admission in the ward at 11 a.m. Provisional diagnosis shows 70 to 75 % superficial to deep burns. The history is given by the daughter – Sunita Shinde. The deceased is stated to be having 3 kids. He is unemployed. Homicidal kerosene burns sustained at 9 a.m. at Railway quarters, Dadar is mentioned in the case papers. The case papers further show that there was no inhalational burns, no history of head/chest/abdomen trauma before or after the incident and no other complaints. It shows a history of stroke 8 years back and it show that he was chronic alcoholic and smoker. His pulse is recorded to be 120/minute and his systolic blood pressure is shown to be 70 mm Hg. He is reported to be pale and dehydrated with no complaint of cyanosis. No other abnormalities are detected. He has been put on treatment, the details of which are mentioned at pages 6-7 of the indoor case papers. The

evidence of P.W.1 in his examination-in-chief as well as his clarification in the cross-examination shows that it was soon after this treatment and the mental condition which came to be recorded that his statement, which is a first dying declaration, came to be taken down. This treatment was in progress when the Police officer reached the hospital. It was then that he orally asked the doctor whether the patient was in a fit condition to make the statement which was replied in the affirmative by the doctor and after which the statement was recorded. The aforesaid history of the patient does not show any serious condition in which no statement can be made. Dying declarations of patients having suffered even 95% burns have been successfully recorded. The deceased had no complaints other than homicidal burns. His systolic blood pressure was reported to be normal. His pulse, though reported to be feeble, was recorded at 120/Min. A reading of the entire medial case papers as a whole, shows that deposition of the Police officer that the doctor replied in the affirmative that the patient was in a fit condition to make a statement is indeed correct. The statement speaks for itself.

29. The statement was signed by the deceased at two places. It has been signed by the officer also at two places. It has been endorsed by the doctor on two pages. Indeed, as contended by the learned APP, the details in the statement could have only been provided by the deceased and none

other. It shows not only that the deceased, though incoherent, made the statement and the officer patiently took it down. It also shows that he made it with peace of mind when he was alone with the officer and without interference of any one. There is no case that any one else could have interfered and tutored the deceased to make the statement. The only relative with the deceased was his daughter Sunita. She was not with the deceased at the time when the statement was recorded, though she, along with her neighbour Mohite, admitted the deceased to the hospital. This is not a statement which could have been fabricated by the officer at a later stage also. A fabricated document would not be expected to be as detailed in its contents and prose as the statement, Exhibit-10, is.

30. It may be mentioned that the evidence of the officer shows that he complied with the requirements of recording of the FIR in the making of Exhibit-10. It may also be mentioned that his cross-examination, in fact, shows the clarification of two material facts that he made inquiries with the deceased for as long as 30 minutes in recording the FIR and that he had asked for written permission of the doctor, though it was given only orally before the recording of the statement.

31. Soon after he recorded the statement, the SEM recorded his statement which is a second dying declaration of the

deceased. The Police Officer collected that dying declaration also. He gave the statement recorded by him to his Constable with direction to obtain the doctor's endorsement which the Constable did at 2.50 p.m. The statement which runs into 4 pages has endorsements of the doctor at pages 1 and 3 in the margin. These are detailed endorsements titled “endorsement certificate”. It shows the date and time of the endorsement. It shows that the patient Yeshwant Ganpat Jadhav was admitted to ward No.5 in Dr.A.N. Supe's unit. It mentions his IPD and OPD numbers as well as the casualty number. It then mentions that the patient was conscious, oriented in time,place and person to give full valid consent and statement. It is signed by the doctor. The same endorsement is repeated at page 3 in the last margin. The officer as well the as the deceased have also signed vertically across the right side margin on page 2 and at the end of page 4. We may mention that we were surprised to find two endorsements of the doctor on a single statement. The learned APP drew our attention to the fact that the statement is indeed lengthy, running approximately in four pages. It appears that the officer expected the statement to be on the first 2 pages. It, however, had to continue. Page 3 shows the statement of the deceased being continued on 1.5.2000 at page 7 of the FIR. Consequently, since the statement was made in two parts, two endorsements were obtained. The

officer has taken care to see the endorsement of the doctor/ signature of the deceased on each page. Consequently, alternate pages bear the endorsement of the deceased as well as the stamp and signature of the officer. We may mention that the officer has taken more than usual care in bringing on record the entire facts of the case as stated by the victim.

32. The doctor-PW4, has identified his endorsement. His deposition shows that the patient was admitted to KEM on 1.5.2000 in ward No.5 under casualty No.6688. He examined the patient. He gave his endorsement which is recorded in his deposition. He identified the endorsement being in his handwriting and signed by him on two different pages of the FIR, Exhibit-10. He has deposed that by that endorsement he meant that the patient was in a fit condition to give a statement. Upon his direct oral evidence, the endorsements have been marked as Exhibit-25 (collectively) in evidence.

33. His further deposition shows reference to indoor case papers also which are in his handwriting and bearing his signature. He had an occasion to examine the patient. The last sentence in his examination-in-chief shows that he had examined the patient at 11.15 a.m. as indoor patient.

34. It must be remembered that the officer reached the hospital before 11 a.m. The officer had seen the treatment in progress. The doctor-PW4 had examined patient before the

officer started recording his statement. The officer took 30 minutes to record the statement. The officer recorded the statement until past noon. The timing of these events falls in place.

35. P.W.2 is the other doctor, who examined the patient immediately upon his arrival and admission to the hospital at about 11 a.m. on 1.5.2000. He noted down the history of the patient given by the doctor. He found the general condition of the patient poor. He recorded the pulse as well as systolic blood pressure. He recorded that he was pale and dehydrated. There was no evidence of cyanosis/icterus. He also recorded that patient's S1 and S2 were normal and tachycardia was present. His cardiovascular system shows right sides hemiplegia and no abnormality was detected in his abdomen. He identified the indoor case papers as being in the handwriting of Dr.Gandhi, P.W.4. He also produced the entry in the casualty medical register of the year 2000 made at 10.20 a.m.

36. His cross-examination shows that in medico-legal cases, a history is obtained from the patient himself and, if he is unable to make statements, from the person who accompanied the patient. In the present case, history was obtained from his daughter Sunita. His cross-examination further shows that considering the condition of the patient, it would require immediate medication to bring him to the

normal condition and to make him talk. The patient with severe burns had laboured breathing. His heart was beating fast. He may develop temperature.

37. It is strenuously urged on behalf of the Appellants that the fact that the history of the patient was taken from the patient's daughter and not from the patient shows that the patient was unable to talk to even give his history. He, therefore, cannot make a dying declaration and no dying declaration of such a patient can be accepted by the Court.

38. It is true that the history is indeed recorded by the daughter. It shows the presence of the daughter along with the deceased upon the incident having occurred and he having been shifted to the hospital by her. However, recording of the history itself would not show that the deceased could not have been in a position to have it recorded himself. The initial provisional diagnosis showed that he had 70 to 75% superficial epidermal to deep thermal burns. His entire face and head were burnt. He was accompanied by neighbour and the daughter. The doctor may, therefore, deem it fit to take history from the daughter who brought in the patient rather than take it from the patient himself. Since the patient was accompanied by her relative, the fact that his statement was not taken by him is not a circumstance which would lead to any conclusion, as has been argued on behalf of the Appellants. In any event,

the cross-examination of the doctor, who recorded the history of the patient and the initial endorsement in the case papers itself shows that immediate medication would bring the patient to normal condition to make him talk. The patient has been given immediate treatment, as reflected at pages 6 and 7 of the case papers. The treatment was in progress as deposed by P.W.1 when he came to the ward upon receiving the telephonic message. The recording of his statement had begun after and soon after the treatment was given to the patient. The treatment that was given to the patient is by IV fluid as well as by injections. This would revive the patient to make him talk. The patient had no history or complaint other than the homicidal burns. Once that is treated, there is no reason why he would not speak. We may mention that though the initial diagnosis was of 70 to 75% superficial epidermal to deep thermal burns, the actual extent of burns shown in the postmortem report is only 55%. It is far below the extent of burns suffered by various other patients of homicidal burns as can be seen from the numerous judgments in that behalf. A reading of the case papers showing the history and the complaint recorded by the doctor, seeing the extensive treatment given to the patient immediately upon admission to the hospital, and seeing the evidence of the two doctors who treated the patients alongside the evidence of the Investigating Officer

who recorded the statement, we are satisfied that the patient was in a fit and proper condition, as per the opinion in the medical records, to have given the statement that he did. We are also satisfied that such a statement could never have been fabricated or given by any one other than the deceased himself.

39. There is no bar upon the Investigating Officer to record any statement. Nevertheless, in this case, the Investigating Officer has exercised further prudence. Even before he recorded the statement, upon seeing the kind of case that he was to investigate, he summoned the SEM to have an independent statement recorded. That statement was recorded soon after the FIR was recorded. That statement is in question-answer form with specific questions printed on the questionnaire which was given to the SEM. The SEM has been examined as P.W.3. He is a Corporator, residing at G.D. Ambekar Road, Parel, Mumbai. He is, therefore, a respectable person from the locality. His deposition shows that he asked the deceased how he received burn injuries. The deceased replied that his wife had illicit relationship with his son-in-law and that his wife poured kerosene on him and his son-in-law set him fire by matchstick. This dying declaration is, therefore, cryptic, precise, concise and brief. It is to the point. It only concerns itself with the burn injuries suffered by the deceased for which the SEM was

summoned. Unlike the FIR, it need not have the past life sketch of the deceased, which was an essential part of the FIR. Nevertheless, the dying declaration shows the reason for he having been inflicted the said burn injuries, as well as the specific roles of the two accused in inflicting the injury. The SEM further asked the injured on what part of the body he received the burn injuries. The injured replied that, that was all over his body. The injuries are shown to be on the complete front part as well as a part of the back. That was because the deceased was bed-ridden. Two bottles of kerosene were poured on him. He was on a mattress and ignited matchstick was thrown on the kerosene which was poured on his body. Consequently, his entire front and most of his back got burn injuries.

40. The injured replied that his daughter Sunita and his neighbour extinguished the fire. Upon being asked whether he had complaint against any one and he had anything else to say, he only complained against his wife and his son-in-law.

41. His statement in question-answer form was read over to him and explained to him. His signature was taken on it. The SEM put his seal and signature. The doctor was on duty at that time. The SEM has proved the dying declaration recorded by him in his own handwriting and signed by the deceased as well as himself by direct evidence. His cross-

examination shows that he was a novice. It was the first dying declaration recorded by him. He took 15/20 minutes to record it. Nobody was present near the patient whilst he recorded it. His daughter was present near him.

42. There is no endorsement of the doctor on this dying declaration. It need not be. Two endorsements of the doctor have been put on the detailed statement recorded by the Police Officer.

43. His cross-examination further shows that he had asked the doctor about the condition of the patient, after which the doctor left the ward and he recorded the statement. He had not taken assistance for obtaining the signature of the deceased. His cross-examination also shows that on that day nobody had informed him that the Police officer had already recorded the statement of the injured before he recorded the dying declaration.

44. The entire cross-examination, in fact, shows the clarification of the recording of the dying declaration as to time and presence of relatives and the doctor and as to its execution. It further shows that he performed his independent duty unaware of the investigation that had commenced. His duty included recording the answers to the questions which were already printed in his own handwriting after obtaining the permission of the doctor, which he took.

45. We may mention that the signatures of the injured have

been put on pages 2 and 4 of his statement before the officer. Those signatures have been proved by P.W.1 against the Police officer by direct evidence. The signature of the injured on the dying declaration recorded by the Magistrate has been proved by the direct evidence of the Magistrate. The case that the dying declaration was fabricated by PW1 and the officer P.I. Kurne cannot be accepted.

46. Though the daughter of the deceased Sunita, who is the wife of Appellant No.2, came to the place of the incident upon hearing the shouts of her father, extinguished the fire by pouring water on his person and took him to the hospital and gave the history of homicidal burns, she as well as the neighbour Mohite have turned hostile. They have been examined as PW6 and 7. It is interesting to note their evidence. P.W6-Mohite, who is the neighbour of the deceased, has deposed that he lived in servants' quarters of the Central Government officers' flats and studied upto standard VIII. He has feigned ignorance about the shouts of the deceased or even whether he went to the Police station on 1.5.2000. He has deposed that one person was present, whose name he did not know, when he extinguished the fire by pouring water on the person of the deceased. He has, however, deposed in his cross-examination that the deceased was not in a position to make any statement. A lot of reliance has been sought to be placed on behalf of the Appellants

upon his opinion. This opinion is contrary to the opinion of two doctors PW2 and 4. This opinion is given by a servant who has studied upto standard VIII. His qualification itself determines the worth, if any, of his opinion, which, at once, deserves to be rejected.

47. The daughter of the deceased examined as P.W.7 has deposed that the deceased was bed-ridden and her mother and she were looking after him for his daily adulation. She has, however, deposed that she, her husband and children as well as mother had gone to Goregaon at 8 a.m. on 1.5.2000 and hence, did not know the cause of the death of the deceased. She claims that the Police did not record her statement, but obtained her signature when she claimed the dead body of her father to take to the cemetery. She claimed that she put her signature once on such statement and then on EPR entry. It may be mentioned that her very presence at the time of the admission to the hospital and giving history of the patient belies her hostile evidence. That fact corroborates the case of the prosecution and is directly contrary to the case of the defence sought to be put up in her evidence. She has also opined that her father was not in a condition to sign since he was suffering from paralysis. Her medical opinion is only in view of the paralysis suffered by the father. She has refuted the signature of her father on the FIR. This is despite the clear proof by direct evidence of

the said signatures by the Police Officer, P.W.1, an independent witness. She has not produced any record by way of specimen signature of the father on any authentic document of earlier date to show how the signature on the FIR is not her father's signature. Neither her statement about her father's signature nor her opinion can be accepted. We may mention that even if the father signed differently earlier, the signature/name that he put on the FIR at two places were under the aforesaid circumstances. He was not only paralysized, but also burnt. He was bed-ridden. He would have put the signature while sleeping on the cot. The signature shows full name of the deceased as is the case of most illiterate or less educated people. It may or may not be identical to his earlier signatures before his paralytic attack or before he was bed-ridden. Subscribing of his full name at the foot of the statement, which is the fact proved by PW1 by direct evidence cannot be upturned by a mere statement made by his daughter in her cross-examination.

48. We may mention that EPR entry 2035 was got made in the EPR register upon the admission of the injured to KEM hospital. It would be for the prosecution to prove the said entry through the relevant Constable who was on duty to maintain the EPR register. Before that could be done by the prosecution, in the cross-examination of PW1 itself, the

accused sought to produce and get proved the EPR entry. Upon that being shown to PW1 in his cross-examination, it has been marked Exhibit D-1 in evidence. Consequently, no other witness has been examined to prove the EPR entry. It is argued that, that entry was suppressed by the prosecution and hence, has been got produced by the accused. A reading of the evidence does not reflect such fact.

49. Paragraph 5 of the cross-examination of PW1 states that he had met the Constable who was on duty at KEM hospital to maintain EPR register. He had seen the EPR entry book. He took charge of the entry. He admitted the entry shown to him. It came to be marked Exhibit D-1. He has deposed that Sunita was present at that time in the hospital. EPR entry, Exhibit D-1, shows that Sunita, P.W.7, showed herself as the daughter of the patient and stated that her mother Vanita (Appellant No.2) poured rockel on the person of her father and burnt him. The entry shows that no other details of the incident are available.

50. Reliance is sought to be placed upon that entry to show that it is inconsistent with the two dying declarations of the deceased. It is argued that there is no mention of the son-in-law in the entry. The mother has been assigned both the rules of pouring kerosene as well as burning the body of the deceased. It is, therefore, strenuously argued that the entire dying declarations should be discarded, it being inconsistent

with and specifically uncorroborated by the EPR entry. It is thereafter argued in the alternative that at-least the implication of Appellant No.2, which finds it place only in the dying declaration of the deceased must be ruled out and benefit at-least be given to Appellant No.2.

51. The learned Advocate on behalf of the Appellants himself drew our attention to the statement of PW7. The statement is much the same as EPR entry and need not be further elucidated. It may be mentioned that the daughter of the deceased, PW7, was not the eye witness to the incident. As per the prosecution case, she had gone out for domestic work in the officers' quarters. As per her own hostile evidence, she had gone to Goregaon. Consequently, her statement cannot be accepted in toto and to the exclusion of the detailed dying declarations made by the deceased as the victim of the incident himself. The dying declarations show that the son-in-law threw the lighted match on the body of the deceased, on which kerosene was earlier poured by the wife of the deceased and he had run away. Therefore, after hearing the shouts of the deceased or upon coming to the scene of the offence, P.W.7-Sunita did not even see her husband at the scene of the offence. She only saw her mother. She, therefore, gave an account of only what she saw immediately after the incident. Being not an eye witness account, it cannot unsettle the dying declarations of the

deceased himself.

52. P.W.5 is the doctor, who made the postmortem of the deceased and has produced and proved the postmortem report. The postmortem report shows the actual extent of burns to be 55%. It is, therefore, more authentic than the indoor case papers which show the percentage of the injuries suffered by the deceased to be only upon provisional diagnosis which is to be 70 to 75%. The postmortem report also shows that the daughter of the deceased stated that her mother had burnt her father and was abusing him. It shows that the deceased was burnt at many places. The places specified are head, face, neck, right upper limb, left upper limb, anterior and posterior trunks. The postmortem report lends further support to the fact that though the deceased was injured by way of burns at many places, he would be in a position to make the statement that he did.

53. It is argued on behalf of the deceased that since no endorsement of the doctor was obtained by the Police officer, P.W.1, prior to the recording the statement and the endorsement was obtained at-least two hours after the recording of the statement through the Constable, it cannot be relied upon. It is also argued that because no endorsement of any Doctor was obtained by the SEM the dying declaration recorded by the SEM must also be discarded. It is argued that, therefore, both the dying

declarations cannot relied upon by the Court. The deceased is seen to have given two consistent dying declarations – one detailed and the other brief and precise. However, in both the dying declarations, the specific roles are attributed to both the Appellants specifically. The mental state of the deceased having been seen, there is absolutely no reason to reject either of the dying declarations. The motive stated by the deceased which prompted the Appellants to cause him injuries and the actual mode of causing injuries shown by the deceased lends support to one another. The history given by the daughter and the EPR entry got made by her specifying the role of her mother alone is upon the fact that she saw as well as hear only the mother immediately after the incident when she came to her house upon hearing her father's shouts and heard her mother abusing the father. It is rightly contended by the learned APP that there is no reason for the Police Officer, doctor or the SEM, to falsely implicate the accused. No enmity on the part of any of the witnesses is shown. The witnesses who proved both the dying declarations are independent witnesses. Their oral evidence has been supported by the documentary evidence which came to be proved through their evidence. The contents of the dying declarations show consistency in both of them. The tenor of the recording of the dying declarations shows that they are cogent and reliable. The core of the

incident is brought out clear. The dying declarations are recorded soon after the treatment given by the doctor and after the oral opinion expressed by the doctor, which came to be endorsed thereafter by the said doctor. There is no reason for the doctor to make a false endorsement. It does not matter that the endorsement is made after 2 hours or even after the death, so far as the doctor making the endorsement makes an honest, truthful endorsement after remembering the case in hand. Hence, when the officer had asked the doctor whilst the injured was being treated and the doctor had opined that he could give the statement, the doctor may endorse that fact even later. The doctor was stated to have been in the ward at the time the dying declarations were being recorded. He came to examine the patient once. The officer as well as the SEM stated that the doctor was in the ward. The doctor is expected to be doing his duty to other patients. There is nothing in law which requires the doctor to put his pen to paper as soon as the dying declaration is recorded. There is nothing also in law to require the Police officer or the SEM who records the dying declaration to himself obtain the endorsement of the doctor. The endorsement is only a written manifestation of the earlier oral act or conduct. In fact, it shows that neither the Police officer nor the doctor fabricated any record. It goes to show the honesty of the endorsement. It may be mentioned

that the dying declaration can be made even orally.

54. Consequently, the contention on behalf of the Appellants that because the doctor's endorsement was made at 2.50 p.m., the dying declarations must be rejected must itself be rejected. In view of the two endorsements put on the statements recorded by the Police officer, a further endorsement on or on the reverse of the dying declaration recorded by the SEM is not required.

55. We have been shown a number of judgments relating to dying declarations. It is too late in the day to contend anything other than the settled law that conviction can be made on the sole basis of a dying declaration, if it is cogent, reliable and truthful. In this case, two dying declarations are not only cogent but also consistent.

56. Mr.Sejpal has relied upon a judgment in the case of ***K. Ramachandra Reddy & anr. vs. The Public Prosecutor*** **1976 SCC (Cri) 473** in which it was held that the dying declaration, which is a result of tutoring, prompting or a product of imagination, cannot be relied upon and the Court must be satisfied that the deceased was in a fit state of mind. We have not found any prompting or tutoring by any one. There was none who would tutor the deceased to make his dying declarations. The doctors found, and we agree, that he was in a fit state of mind to make the statement. The parameters laid down in the aforesaid judgments are

satisfied.

57. Mr.Sejpal has further relied upon an unreported judgment of this Court in the case of ***Ramija Ayyub Bagwan vs. The State of Maharashtra*** **dated 6.9.2007 in Appeal No.860 of 2003** . In that case, two dying declarations were entirely inconsistent. They showed different roles of the family members of the deceased. Having found major discrepancies in both the dying declarations, the Court refused to rely upon them. In that case, the endorsement of the doctor was obtained after the completion of the statement. However, the doctor had not examined the patient before the dying declaration was recorded or ascertained whether she was in a fit position to give the statement. The oral evidence of the doctor showed that he did not remember the details of what happened on that day. The documentary evidence contained in the medical papers did not show the examination by the doctor permitting the recording of the dying declarations. Hence, the endorsement given by the doctor, after recording of the dying declarations, which could not be explained by the doctor in his evidence, was not accepted. In that case, two copies of the declarations were made, original was not produced, xerox copy of one of the declarations was only produced. Requisition letter was sent by the Police Officer to the SJM to record the statement that the patient had committed suicide. The dying declaration was not in the

handwriting of the Police Officer, who gave evidence. Hence, the cumulative effect of the dying declarations could be none other than their rejection. That case is also completely distinguishable.

58. We may refer to the latest judgment of the Apex Court brought to our notice by Mr.Sejpal, Advocate for the Appellants, in the case of ***Nallapati Sivaiah vs. Sub-Divisional Officer, Guntur, Andra Pradesh*** **2007 Indlaw SC 929**. The judgment considers all the precedents of dying declarations, including the case of ***Laxman vs. State of Maharashtra*** **(2002) 6 SCC 710**. It was the test case which has been considered and confirmed in the aforesaid judgment. That was also a case of two dying declarations. It was held that the Court will have to see whether they were true and voluntary and whether they suffered from any infirmities requiring their exclusion. It was further held that the medical evidence in the surrounding circumstances could not be ignored. In that case all the witnesses turned hostile and the prosecution case rested only upon two dying declarations. The doctor did not make any endorsement in both the dying declarations. The deceased was profusely bleeding. His condition was precarious when he was shifted to the hospital. The Police Inspector did not verify from the deceased as to whether he was in a fit condition to give his statement. The deceased had received as many as 63

injuries all over his body. The Police Officer was not aware of any treatment administered to the victim. He also did not verify from the doctor as to whether the victim was in a fit condition to make any statement. He also did not verify the casesheet. The two dying declarations were totally inconsistent. In one of them, the deceased stated that while he was on his way to the cinema hall (where the incident took place) the main accused and three other persons assaulted him indiscriminately with hunting sickles. In the other dying declaration, he stated that the incident took place whilst he was returning from the cinema hall. The deceased was held to be too young and infant to have made a voluntary statement. He was not examined by any doctor. After considering the entire law, the dying declarations contained the earlier precedents, it was held in that case that the dying declarations did not inspire confidence and could not be relied upon. The case is completely distinguishable. Based upon the ultimate ruling of the Apex Court in the said judgment itself, the dying declarations, in this case, demand their acceptance. The deceased had none other than himself to rely upon. His own wife had betrayed him. His own son-in-law had betrayed his daughter. His daughter and the neighbour are neighbours of the Appellants. They, therefore, betrayed him in the evidence. The deceased having suffered 55% burns, and having been

given immediate treatment upon admission was certainly in a position to make a statement that he did. We find no reason to reject the dying declarations of the deceased. We require no further corroboration of those declarations.

59. The learned Judge has correctly considered and concluded that the dying declarations are reliable, trustworthy, cogent, clear and consistent.

60. Consequently, there is no merit in the Appeal. The Appeal is dismissed. The conviction and sentence are confirmed.

(DR.S. RADHAKRISHNAN, J.)

(SMT.ROSHAN DALVI, J.)